VALUES, PRINCIPLES

AND A

VISION FOR THE DELIVERY OF

LONG TERM PSYCHIATRIC CARE

IN SASKATCHEWAN

FINAL REPORT

October 28, 1991

RESOURCES MANAGEMENT CONSULTANTS LTD.
2489 BLOOR ST. WEST, SUITE 100, TORONTO M6S 1R6, CANADA TEL. (416) 762-8186 FAX (416) 762-1963

TABLE OF CONTENTS

1. INTRODUCTION 1
   - 1.1 Background 1
   - 1.2 Study Methods 2
   - 1.3 Organization of This Report 2
   - 1.4 Acknowledgements 3

2. THE PRESENT SITUATION 4
   - 2.1 Resources for Treatment and Care 4
   - 2.2 SHNB Clients, Functions and Facilities 6
   - 2.3 SHNB and the Battlefords 9
   - 2.4 Community Reintegration of SHNB Clients 9

3. ISSUES AND DIFFERING VIEWS 10
   - 3.1 Views From Our Consultations 10
   - 3.2 Views From The Strategic Planning Seminar 13

4. A FRAMEWORK FOR PLANNING FUTURE SERVICES 20
   - 4.1 The Definition of Health, Its Promotion and Determinants 20
   - 4.2 The Inseparability of Mental Health from Health 22
   - 4.3 The Definition of Mental Health 23
   - 4.4 Values and Principles 26
   - 4.5 A Vision for Future Delivery of Long Term Psychiatric Care 30

5. RECOMMENDATIONS ON FUTURE DIRECTIONS FOR LONG TERM PSYCHIATRIC CARE 32
   - 5.1 Applying the Framework to the Provincial Mental Health System 32
   - 5.2 Applying the Framework to Saskatchewan Hospital North Battleford 35

6. CONCLUDING OBSERVATIONS 40
   - 6.1 Overview of Proposed Directions 40
   - 6.2 Further Planning Requirements 41
   - 6.3 A Time for Change 43

APPENDIX A STAKEHOLDERS CONSULTED

RMC

93-00467/

1. INTRODUCTION

1.1 Background

In the fall of 1990, RMC Resources Management Consultants Limited was retained by Saskatchewan Property Management Corporation, acting for Saskatchewan Health (the Department of Health) and particularly the Mental Health Services Branch, to conduct a study of long term psychiatric care in the province. The terms of reference established by the Saskatchewan Health Planning Committee, which directed the study, required RMC to

> *Assist the Department of Health Planning Committee in its efforts at articulating the program philosophy and vision for the future of long term psychiatric care in Saskatchewan, and the particular role to be performed by SHNB (Saskatchewan Hospital North Battleford). Ask probing questions and make suggestions to ensure that this Committee arrives at a proposed system which is:*
>
> *a) appropriate to the needs of several target groups including persons with lengthy histories of psychiatric hospitalization, persons detained under Lieutenant Governor's Warrants and certain mentally ill persons charged or convicted under the Criminal Code, and other persons who require long term assessment and treatment or care and supervision because of significant disabilities due to long term mental disorders;*
>
> *b) coherent in that it responds to the individual needs of clients with appropriate staff, facilities, and programs (the right people doing the right thing in the right place);*
>
> *c) in harmony with the overall philosophy and directions of mental health services in Saskatchewan;*
>
> *d) functional as a specialized component within the Saskatchewan mental health system;*
>
> *e) fit not only for the present, but also for the future;*
>
> *f) sufficiently flexible to allow for adaptation, conversion, growth, or downsizing of components, as unpredictable future events unfold;*
>
> *g) the best possible compromise with respect to the future of SHNB given the interests of various parties and the constraints of economics, location, and juxtaposition with other programs;*
>
> *h) in the best interests of the people of Saskatchewan.*

This report presents the findings and recommendations of RMC Resources Management Consultants Limited on long term psychiatric care and its future delivery in the province.

1.2 Study Methods

RMC reviewed previous Saskatchewan studies on mental health and Mental Health Services Branch (MHSB) documents. Together with members of the Saskatchewan Health Planning Committee we visited model programs in the United States in Wisconsin (Dane County), New Hampshire (Concord) and Vermont (Waterbury, Montpelier). Most important, we consulted with a wide range of key stakeholders in the Saskatchewan mental health system including consultations during site visits to SHNB to become familiar with its programs and facilities (Appendix A).

In addition, we conducted a Strategic Planning Seminar to widen the consultation process (Appendix B). The Seminar provided a forum, primarily for the key stakeholders we consulted with during the study, to further discuss how the future delivery of long term psychiatric care should evolve in Saskatchewan. More than thirty individuals participated in the seminar, responding to findings and issues presented by RMC. Attendance was from a wide range of stakeholders in the system:

- management of the Mental Health Services Branch
- SHNB staff
- private practice psychiatrists
- consumers
- advocates
- NGOs
- academics
- other care providers, including representatives of long term care
- others.

A list of attendees is found in Appendix A.

1.3 Organization of This Report

Our report is organized into six sections. Following this introductory chapter, we outline the present situation in terms of resources, SHNB clients, functions, facilities, and the importance of SHNB to the communities of the Battlefords. We then present issues and differing views expressed to us during our consultations with stakeholders in the system, and during our seminar. A framework of definitions, values and principles, and statement of vision follows. We conclude our report with recommendations and further planning requirements.

1.4 Acknowledgements

We wish to acknowledge the excellent cooperation given to RMC by all involved in the study, and particularly the assistance of the members of the Saskatchewan Health Planning Committee:

- Dr. John Elias, Associate Executive Director, MHSB (Chair)
- Dr. Garry Bell, Director of Programs, MHSB - Central Office
- Ms. Moira Gautron, Director of Patient Care, SHNB
- Dr. Mohammed Hussain, Chief Psychiatrist, Prince Albert Mental Health Centre

This study was conducted by the following members of RMC Resources Management Consultants Limited:

- Mr. Myroslaw B. Kohut, CMC, (Project Director)
- Ms. Antoinette Alleyne, OT(Reg)
- Mr. Peter D. Milne, CMC
- Ms. Barbara C. Voigt, CMC, CHE.

2. THE PRESENT SITUATION

2.1 Resources for Treatment and Care

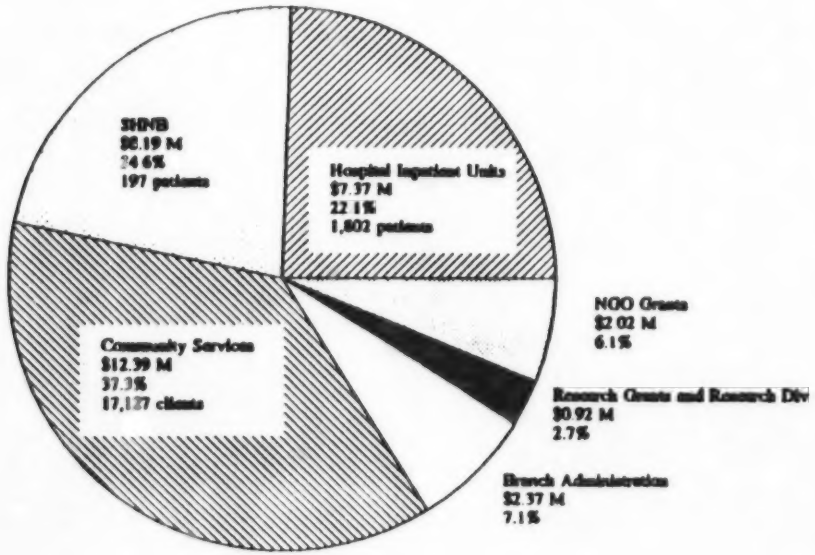
Persons with mental illness in Saskatchewan receive services from six principal sources: (1) community-based services operated by the Mental Health Services Branch of Saskatchewan Health in clinics in eight regions; (2) ten acute psychiatric inpatient facilities in general hospitals, including five inpatient units in general hospitals plus the Weyburn Mental Health Centre operated by the Mental Health Services Branch, and four in base hospitals in Regina and Saskatoon funded by the Hospital Services Branch of Saskatchewan Health; (3) over 20 Non Governmental Organizations (NGOs) funded by the Branch to provide a range of services (members clubs, crisis intervention programs, self-help groups, group homes, supervised apartment living, social and vocational training, and employment activities); (4) over 200 Approved Homes operating in conjunction with the Mental Health Services Branch as part of its community services; (5) private psychiatrists, psychologists, social workers and other mental health workers; (6) Saskatchewan Hospital North Battleford. From the government sector, the Mental Health Services Branch plays a leading role in advocating on behalf of mentally ill persons, seeking improvements in the delivery system, and encouraging public education. From the NGO sector, a corresponding leadership role is played by the Mental Health Association in Saskatchewan, the Schizophrenia Society of Saskatchewan, and the Mental Health Coalition.

In addition, (1) mentally retarded persons are treated in the community through the local school systems, a variety of specialized local facilities and the Community Living Division of Saskatchewan Social Services; (2) the cognitively impaired are generally served through day care, nursing home and District Home Care programs supported by the Continuing Care Branch of Saskatchewan Health; (3) individuals requiring substance abuse counselling and treatment obtain services from the Saskatchewan Alcoholism and Drug Abuse Commission (SADAC); and (4) persons in conflict with the law requiring mental health services are cared for at the Regional Psychiatric Centre (Prairies) in Saskatoon (RPC).

In 1989/90 the Mental Health Services Branch served over 17,127 registered clients through its community services; and 1999 patients in hospital inpatient units, 197 of the latter, at Saskatchewan Hospital North Battleford. The NGOs and Approved Home operators served clients almost exclusively with long term psychiatric illness, as did SHNB. Of the more than 17,000 registered community clients, about 17% suffer from disorders associated with long term psychiatric illness.

In the general acute care hospitals, the total number of admissions in 1989/90 was 4,224, the average daily census was 277 persons, and the average length of stay was 24 days. At SHNB there were 15 admissions, the average daily census was 182, and the average length of stay was 16 years.

Exhibit 1
Distribution of Mental Health Services Branch Expenditures 1989/90



The total $33.26 M excludes:

1. inpatient psychiatric units in Regina and Saskatoon funded by the Hospital Services Branch (about $9.3 M)
2. fees paid to private psychiatrists, psychologists, social workers and other health workers.
3. certain physical plant costs funded by the Saskatchewan Property Management Corporation.

Source: RMC based on data from the Mental Health Services Branch

Total Branch expenditures for 1989/90 were $33.3 million, of which 24.6% was for SHNB, 37.3% for Community Services, 22.1% for inpatient care in acute psychiatric units in general hospitals (excluding base hospitals in Regina and Saskatoon - an additional $9.3 million), 6.1% for NGOs, and 9.8% for Branch Administration and Research Grants. These totals also exclude payments by the Saskatchewan Medical Care Insurance Branch (MCIB) to fee-for-service private psychiatrists, payments made to private psychologists, social workers and other mental health workers, and certain physical plant costs funded by the Saskatchewan Property Management Corporation (Exhibit 1).

2.2 SHNB Clients, Functions and Facilities

Clients and Functions

Of the about 182 persons living in SHNB 59% are 50 years old or more, over half have lived at the hospital for more than 10 years, about one third for over 20 years. More than three quarters have a diagnosis of schizophrenia or affective disorder. While numbers vary slightly, typically there are 22 persons with mental retardation and concurrent mental disorder, and another 20 persons are afflicted by organic brain disorder. Of the total, over 90% are voluntary patients. About fourteen are patients detained by law having been found not fit to stand trial or "not guilty by reason of insanity". The number detained under medical certificates varies. Only small numbers of patients are admitted and discharged per year. About 16 are admitted yearly and about 20 are separated, 10-15 through discharge, 5-10 through death. The average age of patients admitted in the past few years is about 41 years, reflecting increased possibilities for successful reinstatement into the community on discharge.

The focus at SHNB is on both geriatric and long term psychiatric care. Patients progress from highly structured to more independent settings with an eventual goal of community reintegration. The programs offered include:

- assessment
- chemotherapy
- vocational rehabilitation
- physiotherapy
- social and daily living skills
- leisure skills, training and recreation
- vacation programs
- education
- individual and group psychotherapy
- addiction counselling
- family support
- residents' council
- volunteer program
- chaplaincy services.

There are nine nursing units at the hospital, six for patients requiring long term psychiatric care and three for patients requiring geriatric care. The long term psychiatric units are organized to permit progression through a continuum of care involving (1) admission and stabilization, (2) rehabilitation and behaviour management, (3) pre-discharge planning and community reintegration. The three geriatric units are organized to permit progression from geriatric rehabilitation to geriatric maintenance, with early attention given to assessment for community placement. In addition, there are two medical beds for providing nursing care to patients requiring medical nursing care, including care of patients with acute illnesses, those requiring post operative care, and those with a terminal illness.

Patients of SHNB typically enter the hospital with low tolerance to the stresses of day to day life in society. They benefit significantly from the high quality "asylum function" - that is, a safe haven or place of refuge - provided by the staff of the hospital and the programs it offers despite severe fiscal constraints. The treatment links between SHNB and the mental health system beyond its site appear limited. This limitation may contribute to isolation of the hospital and its patients and detracts from its ability to implement a philosophy of normalization. Many family and friends who wish to visit hospital patients must travel long distances to do so. Since it is the only facility of its type, many SHNB patients receive care far from their home community.

Major psychiatric hospitals typically serve five functions (1) refuge, (2) residence - a "home", (3) security, (4) rehabilitation, and (5) acute psychiatric care. The staff of SHNB have made best use of an old deteriorating plant to admirably serve the functions of refuge and residence, and for those that require it, the security function. The rehabilitation function at SHNB is limited due to a serious shortfall in the number of professional rehabilitation staff and the predominant role emphasis on asylum and residence functions. The acute care function is also limited by a shortfall of specialized professional staff resources.

Facilities

The hospital campus occupies an area of about 70-80 acres of land and comprises seven major buildings plus numerous outbuildings, houses, sheds and other smaller buildings. The site itself is part of a 700 acre parcel of Crown land that includes a golf course, a sewage lagoon, the hospital campus and other facilities. Originally developed in 1914, the location of SHNB on the southern outskirts of the city of North Battleford, the campus style of development, and the attractive, tranquil grounds - complete with a cemetery - physically reflect a philosophy of care of the past. On opening the hospital had a census of 346. The total peaked in 1955 with a census of 2,043, requiring the construction of additions and new buildings. By 1967 the census had dropped to 960 because of the introduction of psychotropic drugs, and initiatives often termed the "Saskatchewan Plan", which emphasized outpatient and follow-up care, rural clinics and better trained professional staff. In 1976 a major fire occurred in the main building which occupies about 197,850 square feet. Fire damage affected about 24,300 square feet, an area that has been structurally stabilized and environmentally enclosed, but remains unrenovated, the effects of neglect and residual fire and water damage plainly evident.

In 1986 renovations and additions at a cost of $3.5 million were made to the north wing of the main building to develop a 36,200 square foot, 52 bed unit for the Young Offenders program. Subsequently a gymnasium was developed at a cost of $1.5 million for the program, which also makes use of eight cottages on the hospital campus. Other non-mental health function on the site include a 30-bed corrections unit, a soils laboratory, and other minor functions serviced by the Saskatchewan Property Management Corporation.

A 1989 study by IKOY Architects (Saskatchewan) Limited reviewed the physical facilities. Our own on-site assessment of the hospital facility reaffirms the findings of IKOY Architects. The complex is in varying levels of disrepair and many of the buildings fail to meet current building standards.

IKOY reported the following in their study:

> *The primary concern is the patient accommodation. With few exceptions, patients are accommodated in 16-20 [bed] open wards with little or no opportunity for privacy or individualization. Washroom and bathing facilities are provided in common areas. Recreational and treatment areas are similarly restricted and these programs are often delivered in the wards. Central nursing stations are under-sized and do not allow for appropriate levels of supervision.*
>
> *A special layout of the building contribute to operational inefficiencies and difficulties in providing reasonable living conditions and delivery of therapeutic and recreational programming.*

Some changes have been made since 1989 to provide individual privacy. Despite these efforts patient accommodation remains far below accepted standards.

The lack of indoor recreational and social space was particularly noteworthy, and specifically raised by the Patient Residents' Council. The 1989 IKOY report recommended redevelopment of buildings on the site at a cost estimated at $18.6 million of which the Mental Health Services components were estimated to be $16.5 million based on a complement of 200 beds. Since this was approximately $82,000 per bed for renovated space, concern was expressed at the time by reviewers of the report that the investment in regeneration would not represent good value compared to construction of newly developed space in comparable facilities. Estimates in 1989 for a 32-40 bed new special care home indicated costs of $85,000-$95,000 per bed including land, fees, construction, but excluding financing costs, consulting and project management fees. Total cost of redevelopment would, of course, depend on the scope of what was done on the site, both for Mental Health Services functions and for other functions, and on the building type planned.

Whatever decisions are finally made, if redevelopment on the site is undertaken it will likely be at the cost levels indicated by IKOY Architects, plus inflation, fees and other costs at time of tender. If inpatient units are included in the redevelopment it is likely that their cost will reach beyond 75% of the cost of comparable new construction.

2.3 SHNB and the Battlefords

About two hundred and fifty-two full-time positions allow for employment of local persons at the hospital making it an important contributor to the local economy. SHNB is an established feature of its community. While the hospital and its patients may remain stigmatized to a degree, many would argue that attitudes have changed for the better compared to those held in the past when the hospital had over 2,000 patients. A positive sensitivity to the needs of long term patients has developed over the years. Several community responses benefit the hospital in significant ways, for example, volunteers in the community interact with patients and contribute to their quality of life; SHNB patients visit and receive visitors from long term care facilities in the area; and industrial therapy and other programs produce certain products that are sold locally.

2.4 Community Reintegration of SHNB Clients

The process of reintegrating SHNB clients into the community was strengthened during the course of our study, particularly after our Seminar of February 25 and 26, 1991. A clinical team of SHNB staff assessed all elderly inpatients and identified 24 for possible placement in the community. As a result of a series of ongoing meetings between staff of SHNB and the Continuing Care Branch of Saskatchewan Health, the Executive Director of the Continuing Care Branch sent a letter to all Special Care Homes regarding potential placement of suitable SHNB clients. As well, the Continuing Care Branch requested from the Mental Health Services Branch the list of SHNB clients for potential placement in the community, together with their region of origin and a care needs profile, for transmittal to eight regional contact persons who will facilitate the process of community reintegration. In July 1991, the Community Reintegration Program at SHNB was in the process of filling two positions, a Community Mental Health Nurse and a Social Worker, to work with the present SHNB Social Worker and the Therapist now assisting with the discharge process.

These are positive initiatives. Present clients of SHNB that may be reintegrated into the community will benefit from close cooperation on their behalf by staff of SNHB, the Continuing Care Branch, central office of the Mental Health Services Branch, and community-based programs of MHSB.

3. ISSUES AND DIFFERING VIEWS

3.1 Views From Our Consultations

Key Issues

The following represents a brief synthesis of views on key issues expressed to us during our consultations, together with the underlying questions they appear to reflect. These issues formed a basis for our discussions at the seminar held February 25 and 26, 1991 in Saskatoon.

- There is inadequate funding support, and hence inadequate system capacity, resources and alternatives in the present configuration of services to fulfil needs. One result is an inability to provide adequately for crisis intervention in emergency situations. Another is limitations in rehabilitation, the range of housing alternatives, and in social, vocational and training opportunities in the community sector. A third is a restriction of the roles and treatment capabilities at SHNB and continued use of its antiquated physical plant for service delivery.

  Where should scarce fiscal resources be targeted in the system to ensure service delivery meets needs?

- Coordination and collaborative programming needs to be improved in the system. This applies to interdepartmental coordination, for example, between SADAC and the Mental Health Services Branch (where new initiatives are underway), as well as internally within the mental health system, between NGOs, the Branch, and SHNB. Some claim there is active competition for resources and domains of responsibility between the NGOs and the Branch.

  What improvements can be made to existing mechanisms for coordination and collaboration? What new coordination and collaboration mechanisms are required to ensure planning and delivery better meets the needs of clients and their families?

- Difficult to manage patients are cycled through the system from community living to general hospitals and back, shunted off to SHNB, and occasionally, back to the community. Inadequate attention is given to early identification of high risk clients and to treatment and rehabilitation services for them. There is no consensus on the numbers of such difficult to manage patients nor on the best venue for their treatment, that is, whether care is best provided for them in the community or in a special institutional setting.

  What are the problematic behaviours and needs of difficult to manage patients? In addition to SHNB, who serves clients so characterized, how well do they do so, and with what implications? At what point in their history should/can such patients be identified and who should be involved in identifying them?

- The quality of life of difficult to manage patients living in the community, in group homes, supervised apartments and approved homes, was compared unfavourably by some to the quality of life provided for them through programs at SHNB.

  What are the features of SHNB that contribute to quality of life for difficult to manage patients, and can they be replicated in a community-based program?

- Documented standards and a mechanism for monitoring their application are inadequate in many parts of the system. Quality of care is seen by many to vary beyond acceptable bounds.

  Who should develop and enforce standards? Where has this been accomplished effectively?

- Shortages of qualified manpower exist across many disciplines. Psychiatry, rehabilitation, nursing, psychology, social work, and community support personnel were cited as having short falls.

  What responsibilities does Saskatchewan Health, the Mental Health Services Branch, the University of Saskatchewan and other education institutions have to resolve manpower problems? Who is to take leadership in this matter to avoid floundering?

- Accessibility to services across regions was seen to be unequal. Concern was also expressed over the timeliness of access to services for prisoners of provincial corrections institutions, particularly those who are violent.

  Is it possible to provide universal access to equal care? Where should responsibility be vested for ensuring mentally ill prisoners receive timely access to treatment and care?

- A consensus appears to exist, however, that the time has arrived to resolve the matter of what to do with SHNB.

  What should stakeholders do to precipitate a resolution?

- Concerns exist on the absorptive capacity of the long term care system to accept geriatric residents of SHNB. This concern was expressed both in the context of the present waiting lists for placement in Special Care Homes, reflecting their limited resources, and the present skill-base of their staff.

  Are there any types of behaviours and hence clients that cannot be transferred from SHNB to Special Care Homes? What conditions are necessary to ensure transfer that effectively serves patient interests?

- Concerns also exist on the absorptive capacity of communities to accept more patients with long term psychiatric illness, even if long term care facilities were to be more regionally established.

  What roles should health and social service professionals play to mediate between different interests in society?

- Overall, there appears to be considerable scepticism about the Government's will and ability to adequately fund the system to serve needs - either within existing arrangements or through changed arrangements.

  What is necessary to enable health professionals, consumers, family members, interested parties to transcend scepticism, to develop a shared will, and get on with planning and delivery of future services?

Differing Views on Future Directions for SHNB

A wide range of views is held in Saskatchewan on the future role and needs for SHNB. The spectrum of views from our consultations includes the following.

- SHNB should be regenerated as a 200 bed long term care and rehabilitation centre and become an essential provincial resource for those with severely disabling chronic mental health problems. The facility would be an adjunct to regional community-based rehabilitation services. It would serve (1) high needs patients with chronic disabling mental illness unresponsive to community rehabilitation efforts; (2) patients detained under Lieutenant Governor's Warrants (LGWs); (3) patients requiring long term psychiatric inpatient care.

- Develop a network of psychiatric institutional care that would provide for varying levels of treatment and rehabilitation services *throughout the province* to meet the many different needs of the mentally ill. This would include evaluation units for adults and for children and youth; special needs assessment and rehabilitation units for younger and for older seriously cognitively impaired individuals with mental handicaps or other disorders; residential units with appropriate supportive living services in each division for mentally ill persons from northern and from southern Saskatchewan, that have special intensive needs. This view would also designate SHNB as a mental health facility for young and adult persons in conflict with the law, wind down the role of SHNB in present areas by transferring mentally handicapped patients and others to existing and new facilities noted above, and by admitting no new residents except those in conflict with the law and requiring mental health services.

- A few believe that with the possible exception of persons detained under the Criminal code, an adequately funded system could be based on services provided totally from the community. The range of options would need to be expanded significantly for treatment (including crisis intervention), rehabilitation, housing, social, vocational and training support. Employment opportunities also would need to be expanded significantly but possibly could be done within dollars presently allocated to SHNB operations.

3.2 Views From The Strategic Planning Seminar

Global Themes

Four global themes emerged from the general discussion prior to a review of the issues presented in the previous section.

Support services from the community

Participants were committed to the premise that patients with long term psychiatric illness must have access to the community and its services, including community-based mental health services. Only individuals held in custody under the Criminal Code could be denied access to community-based services. This special group needs mental health services provided within the context of custody and ensuing security requirements. Some at the seminar wanted access to community-based mental health services reflected in a formal philosophy statement for the mental health system. This statement would require the system to *reach out* to the consumer - physically, socially, and programmatically - with required services and a willingness to obtain input from clients on their needs and how best to meet them. The theme of accessibility to the community and community-based services for those with long term psychiatric illness included recognition that balancing community and individual rights is necessary to protect the interests of both, particularly in circumstances of unacceptable behaviour by individuals that are temporarily seriously impaired.

Expanded High Level Partnerships

To ensure effective services from the community a high level partnership of all NGOs and government agencies was seen to be necessary. The partnership would require all parties to work out their respective roles in the interests of their clients, rather than in the interests of protecting turf. Who is responsible for which patients, and what coordination is necessary by whom, were essential questions for resolution among providers if continuity of care were to be achieved. Consumers and families were seen to be key participants in the *Expanded High Level Partnership*. Accountability for the effectiveness and efficiency of service delivery would be required of all.

Provisions in Legislation for Outpatient Commitment/Compulsory Community Treatment

Opinion was divided on this difficult issue. Some providers and family members of individuals with long term psychiatric illness saw the need for legal means to ensure compliance with treatment in the community setting. Another view - of some providers and consumers - questioned the need for a legal remedy, asking whether clients with long term psychiatric illness are essentially different from diabetics or alcoholics. A third view was that certain provisions in both the Mental Health Services Act and the Dependent Adults Act may be sufficient to deal with problems. These existing means should be tried before embarking on the development of new legislation.

Service Commitment of SHNB and Its Staff

Participants recognize that SHNB in its present form represents the end of an era. While the hospital itself was seen to be stigmatized, it was argued that the hospital's staff is contemporary in its outlook, strives to avoid "institutionalization" in its approach to service delivery, and looks to community-based care as a desirable focus for the system and for its clients. The role played by SHNB in enabling the courts to resolve their dilemma of how to deal with certain mentally ill individuals was recognized. More assistance, including more programs and opportunities for placement - potentially in the community - to serve mentally ill individuals appearing before the courts was seen to be necessary.

Views on Issues Arising from Our Consultations

In general our observations on key issues from our consultations were validated by participants of the seminar. Further elaboration of views is provided here.

Serving the Difficult to Manage Patient

There was no consensus on the actual size of the population of "difficult to manage patients". The term "difficult to manage patient" appears to refer to an individual with symptoms that may include unwarranted aggression, extreme dependency, and generally unacceptable behaviours, which might include certain types of sexual deviancy. It was recognized that community-based programs serve patients of this type as does SHNB. Participants also recognized that the term "difficult to manage" was a label reflecting more the incapacity of the system to respond to certain needs than the attributes of an individual person.

One result of system incapacity to meet needs is the shunting of a patient to SHNB, often because needs were not met in a timely and appropriate way in the community setting. This can lead to unrealistic expectations that SHNB can then miraculously reverse the consequent deterioration of the patient.

Keys to responding to the needs of "difficult to manage" clients - also termed "difficult to engage" clients - were discussed. These included: (1) effective case management; (2) better funding to ensure the timeliness of services; (3) greater availability of crises management resources together with follow-on services to free crises beds; (4) increased consumer advocacy; (5) increased support for consumer self-help.

Special Features of SHNB Relative to Community-Based Programs

Important features of SNHB programs were their security, structure and supervision. SHNB programs were recognized to be similar to those offered in the community but were localized in the hospital. An advantage noted by some was that this localization limited logistical and scheduling problems typically facing the case management function in the community. The absence of pressure to leave, acceptance of the patient's functional level, and an atmosphere of tolerance not ensured elsewhere to behaviours were suggested as key features of SHNB. These features enable its staff and programs to stabilize patients and begin a process of rehabilitation. The SHNB features were contrasted with the relatively higher levels of stimulation and therefore relatively more stressful environments of community hospitals and their psychiatric units.

Representatives of community-based services argued that many of these features could be replicated in well-resourced and well organized community-based programs. Participants generally agreed that a secure, structured setting was necessary for some clients for certain periods of time. The preference, however, for many was to develop such settings on a smaller scale, distributed throughout the province, rather than centralized in one location such as SHNB. In this way accessibility to the community, including its services for mentally ill patients, would be better served.

Manpower Shortages

Manpower shortages were seen to be a serious problem in virtually all disciplines. Total numbers of manpower and their distribution were problematic. Differences in remuneration between government and NGO employees, and the general reluctance to work away from the major centres compounded the problem.

While no solutions emerged, there was acknowledgement that university departments in all disciplines have a responsibility to seek resources to ensure training occurs in the province for those disciplines where demand levels are sufficiently high and sustained to permit training in Saskatchewan. The importance of increasing partnerships to this end among educational institutions, providers of care, the community at large and government was recognized.

Special Populations with Needs for Services

The support of the Mental Health Services Branch to help meet the needs of persons in conflict with the law was noted. While those in prison with a diagnosis of severe mental illness are only a few percent of the total incarcerated population, their needs must be better met than at present. Since comorbidity of addictive and severe mental disorders is highest among institutional settings in the prison population, close collaboration of the Mental Health Services Branch and SADAC would be necessary among inmates. The needs of mentally ill native individuals were also raised. As SADAC workers direct their efforts to the native population they are finding more individuals are disclosing for the first time situations with potential for long term psychiatric problems - for example, sexual abuse by a family member as a child. As more such cases are identified in this population, as well as in the non-native population of remote northern communities, there is concern that the long term psychiatric system acquires sufficient resources and develops ways to respond to these special needs.

Views on Future Directions for SHNB

Participants at the seminar discussed the three approaches that emerged from our consultations for developing long term psychiatric care in the province, and a role for SHNB in that system of care: (1) regenerate SHNB as a 200-bed long term care and rehabilitation centre; (2) develop a regional/divisions/community system of care and residential resources throughout the province, in which SHNB would be designated as a facility for providing mental health services to young and adult persons in conflict with the law, and otherwise wind down the role of SHNB by transferring presentations to existing and newly developed facilities; (3) develop an adequately funded system providing services totally from the community.

Three major considerations formed a counterpoint to the discussions. First, there was agreement that a long term psychiatric care is and will continue to be required for many individuals. A comprehensive spectrum of community-based services was seen to be necessary to meet their needs. If such services were well developed there would be a reduced reliance on institutional beds. Future plans for SHNB must take into account the need for long term care and the requirement for a strengthened community-based service delivery system.

Second, community reinvestment was seen to be necessary if a de-institutionalization program were to significantly reduce the role of SHNB from its present level. In the 1960s implementation of the historic "Saskatchewan Plan" decreased investment in SHNB services and its facilities and began the process of building up community-based programs, resulting in the significant decrease in patient census at SHNB. Investment in SHNB continued to decrease in the next two decades but during the 1970s and 1980s there was no corresponding follow-through to further build up the community base. Many participants at the Seminar felt that a government commitment was necessary to build up the necessary infrastructure in the community-based part of the system, and that evidence of progress to this end would have to be plainly evident before they could agree to any substantive reduction in the present inpatient role of SHNB.

Third, there was a strong sense that the economic impact on the Battlefords of any potential reduction in role at SHNB would have to be considered by government. Participants generally believed that the needs of individuals with long term psychiatric illness should be met in the most appropriate manner based on health criteria. If the result was a negative economic impact on the Battlefords, then government would have an obligation to limit this impact. Ideally, new sources of economic activity would have to be found to replace those lost in the event of a substantive reduction in role for SHNB.

We now summarize the three approaches discussed in the seminar for developing long term psychiatric care in the province.

Regeneration of SHNB

Some participants strongly favoured the regeneration of SHNB to enable it to become an essential provincial resource and centre of excellence for long term care and rehabilitation of individuals with severely disabling mental health problems. Representatives of families of individuals presently or previously patients of SHNB praised the role of the hospital in helping the seriously ill. The development of a regenerated facility was seen by such individuals, and by some representatives of the hospital, as a necessary way to continue and improve on past successes.

Development of a Regional/Community-Based System of Care and Residential Resources

This option was elaborated in discussions to clarify where existing patients of SHNB might be transferred, and what types of regional programs and resources might be developed.

Those with mental retardation at SHNB would be integrated into the Community Living Division system of Saskatchewan Social Services. Younger individuals that are organically or cognitively impaired would be integrated into the Continuing Care system of Saskatchewan Health. Individuals over 65 years of age would generally be integrated into the Continuing Care system as well. Others under the age of 65 would be integrated into the regional community mental health system and to specially developed systems of care in the large urban centres.

A number of questions arose concerning the transfer of patients. Among these were

- whether the admission of a specific mental health client to a Special Care Home is appropriate given the clinical history of the mentally ill client and the typical resident in the special care home;

- what special programming and services will be required at the Special Care Home for each mental health client transferred, what will be the cost of such programming, where will the incremental funding come from;

- what support will the Mental Health Services Branch provide to the other divisions during the transition period following admission and afterwards with respect to assessment, care planning, evaluation; will there be provision to discharge an inappropriate admission back to the care of Mental Health Services?

Joint involvement in identifying residents appropriate for transfer, transition planning, and follow-up was seen to be necessary by many. (Subsequent developments have brought together Mental Health Services and Continuing Care Branch staff to coordinate community reintegration of selected SHNB clients. See Section 2.4 of this report).

Development of a Totally Community-Based System

This option was seen by its proponents as the appropriate way to plan for the majority of future patients. In this future context, option (2) above, developing regional systems of care and residential resources, was seen as a transition. An important consideration raised was that newly diagnosed patients and their family members do not expect admission to SHNB. In the absence of adequate resources for timely support from community-based services, as patients deteriorate and their rehabilitation potential decreases, admission to SHNB grows as a possibility and then becomes expected - SHNB becomes the last resort for needed services. By focusing on the needs of new clients entering the system and developing a strong community-based service for treatment including rehabilitation, many saw this pattern, progressive deterioration eventually leading to dependency on SHNB, could be broken.

Towards Convergence and Consensus

The following areas of agreement emerged from the Seminar:

- Long term psychiatric care is needed and will continue to be needed in the province.
- A comprehensive spectrum of community-based services is necessary.
- A review of mental health legislation is necessary regarding outpatient committal, that is, compulsory community treatment.
- A thorough costing of present services to establish the required level of community re-investment would be necessary if services were to be reorganized to decrease SHNB beds. A Plan for long term psychiatric care must be developed. Community-based resources would have to be in place before any major action were taken on SHNB to reduce services. All members of the *Expanded High Level Partnership* would have to be aware of the Plan and transitional requirements prior to bed reductions at SHNB.

- Any transition to a new decreased inpatient role for SHNB would have to take into account impacts on human resources at the hospital: morale, ability to retain existing staff, and to attract new staff during a transition.

- If the role of SHNB were to be reduced, there would be a corresponding need to develop ways to limit the economic impact of the reduction on the Battlefords. For a number of individuals initially opposed to the idea, the development of a facility on the SHNB site to serve the mental health needs of persons in conflict with the law was seen as an acceptable compromise, even though this would not be in full accord with the principal of normalization as they saw it.

4. A FRAMEWORK FOR PLANNING FUTURE SERVICES

4.1 The Definition of Health, Its Promotion and Determinants

We begin the description of our framework for planning future services by defining our terms: first *health*, its promotion and its determinants; then *mental health*. Our major point is that mental health is inseparable from the overall concept of health. The definitions we present are widely acknowledged. Increasingly they are the basis for developing and configuring the delivery of health and specifically mental health services in Canada.

The Definition of Health

The 1948 founding constitution of the World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[1] This definition has been widely adopted since 1948, but its implementation has lagged because of difficulties in making it operational.

Two recent advances contribute to new thinking about health and to the implementation of the WHO definition of health. They are the definition of *health promotion* in the Ottawa Charter for Health Promotion (1986), and a conceptual framework of the determinants of health proposed by Evans and Stoddart (1990).[2] The Ottawa Charter was a joint initiative of WHO, Health and Welfare Canada, and the Canadian Public Health Association, and was officially adopted by WHO. The Evans and Stoddart model (following) has been adopted by the federal/provincial National Health Information Council, by the Premier's Council on Health, Well-Being and Social Justice in Ontario, and is becoming an important basis for policy and program development in a number of other provinces.

---

1 As cited in **Canada's Mental Health**, Vol. 36, No. 4, December 1988, p. 19.

2 Health Policy Research Unit, University of British Columbia, and the Canadian Institute for Advanced Research, McMaster University.

Health Promotion

From the Ottawa Charter, we cite the definition of *health promotion.*

> ***Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.***

As prerequisites, the Ottawa Charter notes that the fundamental conditions and resources for health are *peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.* Improvement in health requires a secure foundation in these basic prerequisites.

Health promotion involves (1) ***advocating*** for health and well-being; (2) ***enabling*** people to achieve their fullest health potential by reducing differences in health status and ensuring equal opportunities and access to resources; and (3) having professional and social groups, and health personnel accept responsibility for ***mediating*** between differing interests in society for the pursuit of health.

Determinants of Health

Evans and Stoddart recently posed a new conceptual framework for examining the determinants of health and relationships among them. The framework features the following key elements (Exhibit 2):

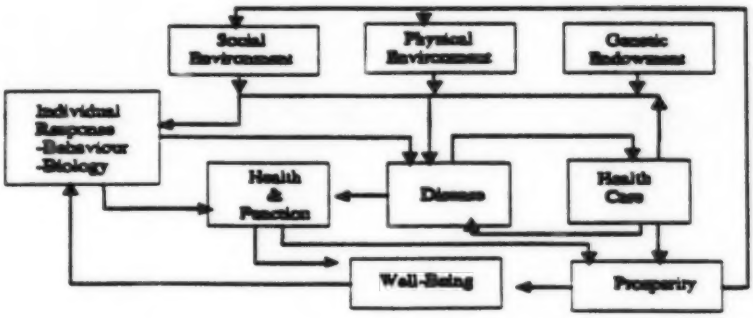
- *A distinction between "disease" and "health and function"* - "Disease" is a concept recognized and responded to mainly by health care providers. "Health and function" is a concept that includes perceptions of illness of individuals, their families and relevant social groups.

- *Incorporation of the concept of "host response"* - We function in a natural and a social environment that contains agents that affect our health in its wider definition. The agents are biological, chemical, physical or social factors that induce stress. Such stress-inducers may affect our health as they reach us through direct exposure, or indirectly through various media for example, water, food, air, jobs, television and so on. "Health" is a function of individual response to factors in our social and physical environments, and is subject to the genetic endowment we inherit. Our response to environmental factors is biological and behavioral and may affect "health and function" - as perceived by individuals. It may manifest itself as a "disease" - as recognized by the health care system.

- *Recognition that "health" is an important, but not sole, contributor to well-being* -Economic prosperity also contributes to well-being. It can do so directly and affect our health by affecting our host response mechanisms. More prosperous people are more likely to be more healthy and respond more effectively to degraded conditions in social and physical environments. Prosperity also can affect the resources allocated to improve conditions in our social and physical environments, and thereby affect individual responses and disease states. In both cases our health is affected, and therefore, our well-being.

Exhibit 2

Determinants of Health, a Conceptual Framework



Source: Evans and Stoddart; 1990

4.2 The Inseparability of Mental Health from Health

We reaffirm: mental health is inseparable from the overall concept of health. The definition of health, its promotion, and its determinants are significant for mental health, particularly when one considers the fragile nature - with respect to environmental stressors - of many who suffer from long term psychiatric illness. If we accept, as Evans and Stoddart outline, that our *health* is affected by factors in our social and physical environments, we must also accept that social and physical environments also affect the state of our *mental health*.

If we accept, as the Ottawa Charter states, that *health* is a resource for every day life, not the object of living, we must also acknowledge the devastating effect of deficits in this resource for persons suffering from long term psychiatric illness. Correspondingly, we also must recognize the need for coordinating an array of health and social services and community resources on behalf of an ill individual whose illness makes it impossible to do so on their own behalf.

If we accept, as the world community has acknowledged through WHO, that prerequisites for health include the conditions and resources of *peace, shelter, education, food, income, a stable eco-systems, sustainable resources, social justice and equity*, we must also accept the special importance these conditions and resources have for persons suffering from mental illness, particularly since their incapacity makes it difficult for them to ensure such conditions and acquire such resources.

4.3 The Definition of Mental Health

The definition of *mental health* and the associated concepts of *mental disorder* and *mental health problem* build on the previous definition of health, its determinants, and relate directly to many of the concepts of health promotion. The definitions that follow and their diagrammatic representation in Exhibits 3 and 4 originated with Health and Welfare Canada[3]. They have been adopted by the Saskatchewan Mental Health Services Branch and their diagrammatic representation combined to provide a conceptual guide to mental health services in the province (Exhibit 5).

Mental Health refers to the capacity of the individual, the group and the environment to interact with one another in ways that promote mental well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.

Mental Disorder is defined as a recognized diagnosable mental illness that results in the significant impairment of an individual's cognitive, affective or relational abilities and which may result from biological, developmental and/or psychosocial factors.

Mental Health Problem refers to the disruption in interactions between the individual, the group and the environment which may result from factors within the individual, including physical or mental illness or inadequate coping skills and which may also involve external factors.

The definitions presented in this chapter provide a conceptual basis for incorporating comprehensive, community-based programming into mental health service delivery. These definitions also support the provision of institutional based care. The most appropriate mix of these two modes of delivery is a matter of values and principles, and their interpretation.

---

[3] **Mental Health for Canadians: Striking a Balance; 1988.**

Exhibit 3

Mental Disorder Continuum

Maximal Mental Disorder (greatest severity, frequency and range of psychiatric symptoms)

Range of impairment and distress (from severe to negligible)

Absence of Mental Disorder (freedom from psychiatric symptoms; effective prevention or cure)

Exhibit 4

Mental Health Continuum

OPTIMAL MENTAL HEALTH

Individual, group and environmental factors work together effectively, ensuring

- subjective well-being;
- optimal development and use of mental abilities;
- achievement of goals consistent with justice; and
- conditions of fundamental equality.

MINIMAL MENTAL HEALTH

Individual, group and environmental factors conflict, producing

- subjective distress;
- impairment of underdevelopment of mental abilities;
- failure to achieve goals;
- destructive behaviours; and
- entrenchment of inequities.

Exhibit 5

CONCEPTUAL GUIDE TO MENTAL HEALTH SERVICES

OPTIMAL MENTAL HEALTH

Clients: Disabled **Focus:** Rehabilitation **Branch Roles:** Coordination Facilitation (funding) Direct Service	**Clients:** Community **Focus:** Mental Health & Well Being **Branch Roles:** Health Promotion Community Empowerment
Clients: Acutely Ill/ Traumatized **Focus:** Treatment & Care **Branch Roles:** Major Service Provider Coordination Regulation	**Clients:** Distressed & Vulnerable **Focus:** Treatment & Enhancing Skills and Supports **Branch Roles:** Service Provider Advocacy Community Development Facilitation (funding)

MAXIMAL — Mental Disorder — ABSENT

MINIMAL MENTAL HEALTH

- Branch Major Service Provider
- Branch & Communities Share Responsibility for Services
- Communities Major Service Providers

Source: Mental Health Services Branch

4.4 Values and Principles

A vision of future service delivery must be based on fundamentally held and shared beliefs. A common value base appears to exist among providers of care in Saskatchewan. The following statements of philosophy or values and principles were presented at the Strategic Planning Seminar and generally accepted. They are based largely on the value base outlined in the document entitled **Core Services**, by the Mental Health Services Branch (September 1990); the **Report of the Task Force on the Delivery of Mental Health** for the Saskatchewan Commission on Directions in Health Care, by a committee under the chairmanship of Dr. David Keegan (1990); A report to the Ontario Minister of Health, **Building Community Support for People: A Plan for Mental Health in Ontario**, conducted by a committee under the chairmanship of Mr. Robert Graham, P.Eng. (1988).

Universal Accessibility

Mental health services must be accessible to all citizens, available through a broad range of human service systems and relevant to appropriate age, regional, cultural, ethnic and geographic dimensions. All citizens must have accessibility to human and physical resources related to assuring their best health care. All citizens must have access to knowledge and information that is accurate, timely and substantiated regarding general health and mental health.

Public Awareness

Universal accessibility can only occur if health promotion, public education and early detection includes information on mental health and mental disorders on an equal balance with other sectors of health information. Citizens, community leaders, human service systems and decision makers must be continuously aware of the extent and magnitude of mental health problems and disorders with the population and the degree to which their legitimate needs are or are not being fulfilled in the overall health system.

Respect for Individual Rights

Respect for individual rights is a fundamental value. The system must ensure individual rights are protected, particularly in circumstances that may require that rights be abridged for the individual's or society's good.

Normalization

The essence of normalization is mainstreaming and destigmatization. All individuals with mental health problems and mental disorders should have full right of access to community services and to adequate living and working conditions. Every attempt must be made to treat the mentally ill in close proximity to their own family, work and community environment, utilizing all human service systems that are accessed by the general public.

The system needs to encourage individuals to function as normally as possible within their family, neighbourhood and community setting. Every effort should be made to reduce the stigma that is all too often associated with mental disorders and with mental health services. Wherever possible, such services should be offered in conjunction with other health and human service organizations. Safeguards must be put in place to prevent the exclusion of people with mental health problems and the mentally disordered from the natural human service resource sector.

Individual Focus

Health promotion, treatment and rehabilitation should be tailored to take into account each individual's unique circumstances, symptoms, condition, abilities and disabilities.

Individual service plans should clearly outline goals, specific treatments and services. Obligations of the individual and of the care providers, in terms of service provision should be developed for all individuals within the mental health system.

Shared Responsibility, With Consumer and Family Involvement

An appropriate balance between the responsibility of the individual and the responsibility of their family or society is important for the best operation of all human systems, including the mental health care system. Individuals and their families must have the right to make informed choices on their treatment and rehabilitation options, based on accurate and understandable information.

In planning and operating a mental health system, the individuals served by the system and their families should be involved at the treatment and rehabilitation level, as well as in the decision making processes at the systems level.

Individuals with mental health problems must be encouraged to assume as much responsibility as possible for the maintenance, treatment and rehabilitation of their own health while considering their mental health circumstances. They should be as accountable for their actions as possible. This philosophy should not be interpreted to mean that providers are not also responsible and accountable to give their best efforts to assure that individuals keep up with the mutually agreed upon treatment and rehabilitations programs.

Comprehensiveness

It is important that individuals with mental health problems and mental disorders have ready access to a comprehensive continuum of multidisciplinary care resources. These must include crisis intervention, treatment, rehabilitation, housing, vocational services, and community support.

Continuity

The service system must provide for the continuity of care and ensure that integration takes place at the client, program and system levels. There must be good interagency communication links, a full range of services, individualized treatment with distinct services to local cultures and a tolerance and realistic acceptance of the difficulties and deficits of the mentally ill. This must include access to residential resources, internal assessment mechanisms and appropriately trained general and specialized care-giving personnel.

Case Management

Case management must be an integral part of service delivery. Individual case managers must be identified and made responsible and accountable for ensuring continuity of care within the system through a process of (1) outreach and case finding; (2) comprehensive individualized assessment and planning; (3) service coordination; (4) direct service provision; (5) monitoring and evaluation of continuing needs; (6) meeting special needs.

Quality

Services for the mentally ill must consistently be of good quality. The mentally ill have every right to expect the same standard of treatment and care as those suffering with physical ailments. It is absolutely crucial that there be explicit guidelines capable of being evaluated and that standards of care be followed by all individuals and agencies delivering services within the mental health field. Quality care is dependent upon on ongoing, careful evaluation.

Community Orientation

Local and district communities are the most knowledgeable regarding their own particular environments, issues, strengths and weaknesses, opportunities and services. They should, therefore be responsible for planning of local needs and operating service systems within the framework of a comprehensive system.

In organizing service delivery programs, local needs must be recognized and innovative programs developed by the local areas should be encouraged and supported.

Caregiver Sensitivity

The caregivers should be highly regarded and valued as part of the community of care. There must be professional and paraprofessional training expertise, motivation, community organization, patience, sense of humour, assertiveness, flexibility and need to work effectively with individuals with mental disorders. These care givers need an opportunity to feel supported to utilize skills and the best of their ability in a most organized compliant fashion to serve the needs of the various levels of the mentally disordered individuals.

Partnership

The mental health system must plan and deliver its services through partnerships. The necessary partnerships are between individuals and their support systems and between the delivery elements of the mental health system and other service providers. Interdisciplinary and interdepartmental partnerships for planning and service delivery are particularly important between Mental Health, Continuing Care, Community Living, Social Services, Justice/Corrections, and the Saskatchewan Alcohol and Drug Abuse Commission.

Flexibility

The mental health system must be flexible. The care system must be sensitive to the needs of the individual and be able to adapt or modify treatment and rehabilitation programs, as circumstances change. Individual service plans should clearly outline goals, specific treatments and services. Obligations of the individual and of the care providers, in terms of service provision should be developed for all individuals within the mental health system.

Functional Equivalency

Services must be developed in a manner that recognizes a variety of service interventions can meet the same need.

Accountability

Supports and services should be monitored, evaluated and adjusted in order to remain appropriate and responsive to changing client needs. Consumers, family members, as well as service providers, need to be involved in the development, operation and evaluation of services.

Efficiency, Effectiveness

The mental health system must be committed to making the best possible use of available resources. Planning and delivery should encompass more than the narrow range of traditional services. Service should be evaluated in relation to their effects on quality of life as well as outcome measures.

Fair and Equitable Allocation of Resources

The system must strive to ensure fair and equitable distribution of resource across the province.

Balanced Service Delivery System Sensitive to Client/Patient Needs

There must be a balance between the delivery of treatment, prevention, and promotion activities.

Priorities

The service delivery system must base its priorities on client/patient needs. Priority for treatment and rehabilitation should be given to those individuals with the most serious, disabling and continuing mental disorders because of extreme complexity and costliness for the individuals, their families and society.

4.5 A Vision for Future Delivery of Long Term Psychiatric Care

Consistent with the delivery aims of the Mental Health Services Branch, positions taken by the major NGOs in the field of mental health in the province, and views of many mental health professionals and academics, we envision a mental health system that is integrally part of the larger system of delivery of health services. The future delivery system for providing services to persons with long term psychiatric illness should build on present capabilities, and should significantly strengthen and enrich community-based services through the development of multi-component service functions. Consumer and family involvement, and community and supportive living services are fundamental to our vision.

In particular, the future system of delivery should develop and adequately fund the following functions, largely based on the work of Dr. Aldred H. Neufeldt, a well known psychologist, formerly of Saskatchewan.

1. Promotion, Prevention and Early Intervention

- Information
- Mental Health Promotion Activities
- Outreach and Client Identification

2. Mental Health Treatment Services

- Crisis Intervention
- Crisis Stabilization Services
- Diagnostic Evaluation
- Medication Management Services
- Counselling/Psychotherapy
- Day Treatment Services
- Outpatient Treatment Services
- Short/Long term Inpatient Treatment
- Special Services for Special Needs Populations

3. Community Housing Services

- Temporary Housing (a few hours to a few days)
- Transitional Housing including Transitional Apartments and Community Residences
- Indefinite Housing
- Supervised Apartments and Group Homes
- Housing with Special Care Components (e.g. physical care, behavioral emphasis, etc.)

4. Skill Development and Rehabilitation Services

- Rehabilitation Assessment
- Social/Community Living Skills
- Educational Services
- Employment (Job) Skill Development including Transitional and Supported Employment

5. Community Support Services

- Personal Support for clients and families including psychosocial counselling
- Respite Services
- Financial Services (e.g. Special Needs)
- Recreation/Social Services-Access Support

6. Case Management

- Case Management Services

7. Advocacy (and Protection)

- Self-advocacy support
- Group advocacy
- Legal Advocacy

8. Coordination

- Planning and Development
- Resource Coordination
- Service/Resource Information.

5. RECOMMENDATIONS ON FUTURE DIRECTIONS FOR LONG TERM PSYCHIATRIC CARE

5.1 Applying the Framework to the Provincial Mental Health System

Based on our review there appears to be substantial agreement on what is required in the future in the Saskatchewan system of mental health service delivery. In part, this is due to the leadership role of the Mental Health Services Branch in articulating values and principles, planning and delivering programs, and advocating for system improvements. Equally, it is due to the commitment, advocacy, and support of major NGOs, such as the Canadian Mental Health Association in Saskatchewan, the Mental Health Coalition, the Schizophrenia Society of Saskatchewan, and many clinical and academic mental health professionals.

What is required is a wider recognition of the existing accord on values and principles for planning future delivery of services, and indeed, a wider recognition of the considerable degree of agreement among key system stakeholders on specific directions to be taken in the delivery of long term psychiatric care.

Our review and the input we received from key stakeholders in the system reflects this agreement and leads us to recommend the following actions for the Mental Health Services Branch.

R1 Ensure Mental Health Services Branch programs, as a priority, serve people with long term psychiatric illness and residual long term disabilities.

There are about 3,100 persons in Saskatchewan suffering from severe disabilities due to long term mental disorders. These individuals have needs for care and support that are among the greatest of any population in the province. The provision of long term psychiatric care and support for these persons should be a priority for the Mental Health Services Branch and all its service delivery components. "Priority" for long term psychiatric care should extend to Branch activities in (1) planning and policy development, (2) acquiring more resources, (3) allocating resources, (4) protecting the resources during budget cuts, (5) ensuring front line service delivery reflects priority for long term psychiatric care.

It is not our intent in this recommendation to suggest that resources should be exclusively directed to those with long term illness. We recognize there are many persons with mental illness that is serious, requires treatment and care, but does not result in the prolonged, severe disability, and often recurrent disorders characterizing long term psychiatric illness. Balancing priorities for allocation of resources to care for these two different populations will always be necessary. In our view, those with long term psychiatric illness have the greater need and will continue to require a priority response by the Branch.

R2 Make "Reaching Out" to those with long terms psychiatric illness a part of the Mental Health Services Branch statements of mission, value base, and objectives.

Identifying persons with long term psychiatric illness in the Mission Statement affords them special attention and strengthens the priority of programs targeted to them. "Reaching Out" recognizes these individuals are often difficult to engage socially and emotionally and therefore programs and services must reach out to them. It also implies providers of care and those that manage its delivery from any venue, community or institutionally-based, have an obligation to look outward from their venue rather than inward, and to deliver programs from this outward looking perspective.

R3 Adopt and implement the definitions, values and principles, and the vision for the future delivery of long term psychiatric care described in Section 4 of this report as a basis for future planning. Incorporate these into the Mental Health Services Branch statements of mission, value base, and objectives.

We recognize that the statements of Section 4 maybe require some degree of refinement and adaptation. Our intention is for the Mental Health Services Branch to incorporate these concepts as quickly as possible and proceed with their implementation. This should not be difficult to do. The directions we offer are in accord with those presented in the Branch's Core Services document of September 1990, **Promoting, Preserving and Restoring Mental Health.** Values and principles we present are based on material in this Branch document and on material from two other recent reports on mental health, one of them from Saskatchewan. While the functions for a long term care system we outline in our vision statement closely follow those developed by Dr. Aldred Neufeldt, formerly of Saskatchewan, they are comparable to functions already put in place to some degree by the Mental Health Services Branch, and espoused by many others in the field of mental health. For example, the Canadian Mental Health Association in Saskatchewan espouses a plan of action for persons with long term psychiatric illness focusing on the following services:

- crisis intervention to case management
- short term and long term medical care
- housing and residential programs
- social/recreational programs
- vocational training and employment programs
- self-help
- family support
- income security[4].

---

[4] **The Future Directions of Mental Health Services for the Long Term Seriously Mentally Ill in Saskatchewan**, the Canadian Mental Health Association in Saskatchewan, April 1990.

We offer two further recommendations affecting the Branch's statement of mission, value base and objectives:

*R4 **Explicitly incorporate into the Mental Health Services Branch statements of mission, value base, and objectives the concepts of (1) health promotion, as described in the 1986 Ottawa Charter for Health Promotion, particularly the definition of health promotion and the concepts of advocating, enabling and mediating; and (2) the framework of determinants of health by Stoddard and Evans, to establish a health-based agenda for the functions of the future delivery system for long term psychiatric care.***

*R5 **Develop treatment and support services for special needs populations, including: (1) natives, (2) children and youths, (3) elderly, and (4) prisoners of provincial corrections, institutions with long term psychiatric illness.***

We recognize much of the thinking underlying the Branch's **Core Services** document reflects the intensions of **R4**. By making explicit use of the concepts of health promotion and determinants of health as outlined in the two sources we identify, we believe the Branch and front line staff will have a health-based agenda to refer to, and therefore will be better equipped to develop programs and present the case for their required resources.

We also recognize that the Branch's **Core Services** document already includes Child and Youth programs, thereby acknowledging this target population as a special needs group. Explicitly identifying the other three groups noted in **R5** will serve to focus attention and priority to their needs, the Branch's planning and delivery efforts to meet them, and requirements for the Branch to work closely with other government departments that serve these target groups (for example, Continuing Care, Corrections/Justice).

*R6 **Adopt in principle the following order of priority to balance program development and funding of services for those with long term illnesses: (1) crisis intervention and management; (2) graduated system of housing; (3) social and recreational programs; (4) financial support to ensure acceptable quality of life; (5) educational and vocational programs; (6) patient programs at general hospitals; (7) long term care for special needs populations requiring new initiatives; (8) natives and prisoners of provincial corrections institutions.***

We suggest this order of priority as a way to precipitate further planning and resource allocation decisions by the Branch. The particular order in **R6** was suggested for consideration towards the end of our Strategic Planning Seminar. We support this order. More specifically, regarding the first two priorities of **R6**, we agree with the position taken by the Canadian Mental Health Association in Saskatchewan, we support the intentions for program development at the Mental Health Services Branch, and therefore, we recommend the Branch undertake the following:

R7 Expand and extend the crisis and case management model established in Saskatoon and Regina as a Core Service in all regions in Saskatchewan.

R8 In the development of a graduated system of housing, consider expanding the Saskatoon Housing Coalition and Phoenix Residential Society models on a per capita basis to all regions in the province.

Combined with recommendations found in Section 5.2 following, recommendations **R1** to **R8** establish a basis for specifying the system of long term care in the province.

5.2 Applying the Framework to Saskatchewan Hospital North Battleford

Our mandate was to assist the Department of Health Planning Committee with its effort at articulating a vision of the future of long term psychiatric care in the Province. We believe community-based care incorporating the principles, values and directions of **R1** to **R8** is not only an important feature of some of the best programs available anywhere at present, but is the best direction for programs to follow in the future. Our fundamental recommendation in respect of SHNB therefore follows:

R9 Apart from necessary interim measures to ensure the care of clients presently at SHNB, we recommend that Saskatchewan Health and the Mental Health Services Branch focus its efforts on developing a community-base for all its future programs. We advise against the redevelopment of Saskatchewan Hospital North Battleford in its present role.

In making this recommendation, we recognize our view will not be the one favoured by some. For example, many competent and devoted staff members of SHNB that have hoped for some time for a new facility will be disappointed by our recommendation. Some psychiatrists and other mental health professionals from outside the Battlefords will also be disappointed, believing that a centralized facility such as SHNB is necessary for treating certain difficult to manage patients. Present SHNB clients and their family members will be apprehensive, as will the staff of the Continuing Care Division and its programs. Many residents of the Battlefords will be concerned about the winding down of SHNB. Scepticism that anything at all will happen will also come from many quarters, as will the fear that SHNB will be dismantled without a corresponding reinvestment in community-based services.

We believe that disappointment, apprehension and scepticism can be overcome. We fully appreciate the potential economic impact on residents of the Battlefords of decreasing the role of SHNB, but we believe alternative solutions to the economic implications of doing so must be found. Our team cannot justify to itself continuing to treat some persons in a long term psychiatric hospital simply to provide employment for others.

Many will agree with our recommendation, having come to a comparable conclusion themselves: for example, the Canadian Mental Health Association in Saskatchewan, the Regina Coordinating Council for Psychiatric Rehabilitation, the Saskatoon Regional Rehabilitation Planning and Coordinating Council, and many mental health service care givers, academics and professionals.

In our opinion, the majority of providers of care in the province believe it is better to fund the development of a community-based system of long term care that includes smaller regionally distributed facilities than to use equivalent funds to rebuild SHNB itself. Many also believe that the aim of the Saskatchewan Plan to ensure accessibility to care as near as possible to the community patients come from should and can be met.

Our seminar included discussion of a sound option to achieve these aims. The option was presented in the report of the Task Force on the Delivery of Mental Health Services (DOMHS), and described by Dr. Keegan at the February 25 and 26, 1991 Seminar of this study (Dr. Keegan was the Chairman of the DOMHS Task Force). Based on our own views and on the responses to the option we heard at the Seminar we recommend the Mental Health Services Branch take the following action.

R10 ***For individuals presently at SHNB: (1) integrate 22 mentally retarded individuals to the Community Living Division system of Saskatchewan Social Services; (2) integrate 20 organic/cognitively impaired younger individuals into the Continuing Care System of Saskatchewan Health; (3) integrate 40 individuals over 65 years of age into the Continuing Care System; (4) integrate 100 individuals under 65 appropriately into the Regional Community Mental Health System and the new broad continuum of residential resources specially developed as described in R11 following.***

R11 ***Formulate and implement a ten year plan which makes available:***

(1) an enhanced community-based system of clinical and consulting services including community crisis intervention and assertive case management in each mental health region;

(2) a broad continuum of residential services which includes, in addition to existing minimal supervision apartment living programs, approved family-operated homes providing board, room, and supervision, and licensed group homes operated by NGOs: (a) a variety of resources in each region which enhance the capacity of existing residential services to provide long-term accommodation to people who, because of severe or persistent mental disorder, present significant challenges in

daily living (such as mobile shift workers to assist operators during high stress times, "sitters" to provide supervision, staff qualified to provide behavioral training, social and recreational activity programs, etc.); (b) crisis stabilization teams in Saskatoon, Regina, and other large centres, with one or more residential spaces available to each, with the capacity to receive mentally disordered persons when they are in a state of crisis where there is no medical reason for their admission to hospital, to provide short-term accommodation and stabilization services; (c) several small, regionally distributed, specialized long-term homes with a mixture of professional staff, which offer intensive behavioral training and close supervision and support, which are designated under the provincial Mental Health Services Act as facilities in which persons may be detained under specified conditions if necessary, with a total capacity of about 40 spaces, each in the range of 8-12 spaces; and (d) about 20 spaces in long-term care facilities across the province in which special programs are provided for elderly persons with cognitive impairments;

(3) a system of day and evening programs in each region including training in social and other basic life skills, pre-vocational training, vocational skills training, supported employment programs, and social and recreational activities;

(4) hospital-based resources including: (a) a system of acute psychiatric beds in general hospitals in all mental health regions, the number in each region proportional to the populations served (correcting for the current maldistribution); (b) plus about five extra psychiatric beds at the Royal University Hospital dedicated to serving persons referred from all regions of the province who have not responded to standard treatment or rehabilitation programs, where they may receive specialized multi-disciplinary assessments and where effective programs of treatment or rehabilitation may be formulated for them; (c) possibly a small number of beds at the Wascana Rehabilitation Centre dedicated to provide specialized resources to relatively young individuals with cognitive impairments; and (d) a specialized mental health facility with about 30 beds for adults in conflict with the law who must be treated under conditions of security, to be developed on the campus of the Saskatchewan Hospital North Battleford.

The approximate current value of estimates of the cost of regenerating facilities for mental health functions at SHNB is in the neighbourhood of $20 million (refer to page 8). It would be more effective, in our view, to direct this level of funding to develop and implement the ten year plan of R11. We therefore recommend Saskatchewan Health:

R12 Develop the ten year plan of R11 within a target construction cost of $20 million (1991, second quarter dollars) plus the costs, as required, of financing charges, and consulting and project management fees.

To ensure the new regionally-based system can meet patient needs effectively we recommend the Branch also undertake the following four activities:

R13 ***Review the Mental Health Services Act and Dependent Adult Act and propose any required changes in legislation that will address the matter of compulsory community treatment in the context of R11.***

(We understand action on **R13** is underway.)

R14 ***Develop in conjunction with R11 ways to strengthen mechanisms for coordinating services and resources, including as necessary, the mechanisms of (1) revised catchment areas; (2) development of a single entry point system; (3) case management; (4) case registry and patient tracking.***

R15 ***Develop in conjunction with R11 a mandatory orientation and training program for present Approved Home Operators, operators proposed for the full range of future graduated housing facilities, including requirements for facilities indicated in R11.***

R16 ***Develop in each region mobile teams of mental health workers and volunteers to provide social rehabilitation and support programs to clients as proposed in R11.***

To ensure smooth transition from the present way of delivering services to the system specified in **R11** the Mental Health Services Branch should:

R17 ***Develop a transition plan, jointly with community with the Continuing Care Branch, to transfer and integrate patients presently at SHNB as recommended in R10; the transition plan to address items of mutual concern to the Mental Health Services Branch and to the Continuing Care Branch.***

We note that initial progress toward **R17** is already underway for a selected elderly group of 24 clients as noted in Section 2.4 of this report. No formal commitment was evident during our study for reintegrating any other SHNB clients.

R18 ***Develop a transition strategy and plan with input from SHNB staff and administration, to maximize opportunities for staff redeployment into community-based programs, and to minimize negative transitional impacts on (1) staff; (2) patients; (3) delivery of services in the interim at SHNB.***

We recognize the transition away from the present role of SHNB will take time, although practical realities will require as brief a transition period as possible. In the interim, certain improvements and maintenance to SHNB facilities will be required. Improvements that enhance the privacy and dignity of the patients need to be made even if the transition period is as brief as one year.

The Residents Council and a former patient of SHNB developed a presentation that was made to RMC during our visit to SHNB on January 10, 1991. The presentation expressed needs and suggestions for improvements to recreation and living spaces, the family cottage, as well as programs, including education, work and others. We therefore recommend the Mental Health Services Branch:

R19 ***Develop a strategy with input from SHNB staff and residents for interim capital improvements facilities and equipment at SHNB, giving priority to patient-centred needs, particularly as expressed in the presentation to RMC of January 10, 1991 by the Resident's Council.***

Finally, to build the base of human resources for delivering services in the new system, we recommend Saskatchewan Health and the Mental Health Services Branch:

R20 ***Initiate a three year program to develop: (1) standards of care and service delivery; (2) a manpower plan identifying human resources required by discipline, by year, together with projected supply levels and, strategies for filling deficits in supply. This program should involve wide representation from the Branch, NGOs, and educational institutions, and should project manpower needs to year 2001.***

6. CONCLUDING OBSERVATIONS

6.1 Overview of Proposed Directions

This study set out to provide advice to the Saskatchewan Health Planning Committee on the future of long term psychiatric care in the province. The framework for future planning in Section 4 and the recommendations in Section 5 of this report constitute that advice. Our statements of values and principles, vision of future care, and recommendations for further developing the present system build on the historic innovations pioneered in the mid-1950's in Saskatchewan by Dr. D.G. McKerracker and Dr. F.S. Lawson, subsequently known as the "Saskatchewan Plan". These innovations led to the present structure of the long term psychiatric care system. As sound as the present system may be in theory, evidenced in part by the many jurisdictions that have taken the same road as Saskatchewan toward deinstitutionalization and ensuring care is provided as close as possible to the patient's home community, the present system cannot meet the needs of its clients effectively. The main problem is lack of adequate resources.

This problem is particularly acute and poignant for one of the oldest components of the present system, Saskatchewan Hospital North Battleford. SHNB represents the end of an era despite the remarkable efforts of many of its staff and the funding and physical limitations they face. To regenerate the hospital facilities and programs would require a major investment of capital funds. The result of such a regeneration, in our view, would be investment in a vision of the past.

Our report looks to the future - to patients who will present with long term psychiatric illness, and to leading contemporary approaches for delivering services to meet their needs. We recommend spending capital funds, equivalent in amount to what would be required to regenerate SHNB, but we recommend the expenditure be directed at developing physical infrastructure for a regionalized community-based system. The system we propose, in common with contemporary views and practice, features enhanced crisis intervention and management, a graduated system of housing, coordination of services and resources, mobile social rehabilitation teams and other innovative approaches to providing treatment and care.

An important basis for the vision of the system of treatment and care we propose in this report lies in the concept of health promotion. We seek ways to enable persons with long term psychiatric illness to increase control over their health and to improve it. Since their disabling mental disorders make it difficult for many to ensure for themselves critical prerequisites to health and well being, we recommend programs to help secure these prerequisites: adequate shelter, food, income, sustainable resources, and so on.

Our report also addresses the needs of present residents of SHNB. Their integration into the Continuing Care system and new regional long term care facilities to be developed should occur on the basis of a transition program planned with the joint involvement of staff of the Mental Health Services and Continuing Care Branches. We also recommend the development of a second transition program, the aim of which is to maximize opportunities for redeployment of SHNB staff into the community-based programs and to minimize negative impacts of the transition on staff, patients and service delivery capabilities of SHNB during the transition.

6.2 Further Planning Requirements

Our report provides strategic directions for long term psychiatric care in the province. To realize these directions a *Long Term Plan* is required. Steps required to develop and implement the *Long Term Plan* include:

- reviewing this report in consultation with key stakeholders and seeking government approval to proceed;
- developing a set of planning "packages" comprehensively covering approved directions, and elaborating each "package";
- identifying resources required for each "package";
- scheduling implementation of the "packages";
- developing an organization for project implementation;
- seeking government approval and proceeding with implementation of approved, costed and scheduled "packages" - the *Long Term Plan*.

One of the important benefits and impacts to date of this study is the good will built up among key system stakeholders. This good will is the result of the open, consultative approach taken by the Saskatchewan Health Planning Committee, particularly the process leading up to and including the Strategic Planning Seminar of February 25 and 26, 1991.

Many important changes are proposed for the system of long term psychiatric care. Their accomplishment will be made easier if key individuals affected by these changes become stakeholders in the change process. This is more likely to happen if they have input into planning and decision making.

We therefore recommend the Mental Health Services Branch:

R21 ***Continue in further planning the open, consultative process traditional to the Mental Health Services Branch as demonstrated in this study.***

Finally, we wish to recognize the important concerns of many residents of the Battlefords. Winding down the present role of SHNB will have an economic impact on the region. The economic benefits of our proposal to develop a facility for treating young and adult persons in conflict with the law on the SHNB site would fall far short of losses resulting from the decreased inpatient role unless compensating action is taken.

We therefore recommend the Government of Saskatchewan:

R21 ***Work with representatives of the residents of the Battlefords region to develop alternatives to limit economic impacts of the decreased inpatient role proposed for SHNB.***

During our study we recognized that the physical facilities and site of SHNB represents a special community resource to the residents of the Battleford region. Upon integration of present residents of SHNB into other facilities and community-based services, empty buildings will be left at SHNB. We therefore recommend the Government of Saskatchewan:

R22 ***Commission a study involving Battleford community representatives to review alternative community and other uses for buildings and unused land at the SHNB site upon winding down of the hospital's role and refocussing it to care of young and adult persons in conflict with the law. The study should examine realistic costs and benefits of required redevelopment, and sources of operating and capital funds for alternatives involving community ownership, management, and use.***

The process of winding down the present role of SHNB and refocussing it would be of considerable interest to many in the Battlefords region - and contentious for some. To ensure residents know what is happening, we recommend the Mental Health Services Branch.

R23 ***Develop and implement an ongoing communications plan to apprise residents of the Battleford region of progress towards approved role changes at SHNB.***

6.3 A Time for Change

Is change possible? Sceptics will point out this report is at least the tenth on mental health in twenty-five years. Few would seriously argue, however, that the present system of long term care is no better than it was twenty five years ago. Despite the fact that the province has lost much of the leadership role in mental health it once enjoyed, people still look to Saskatchewan to see how it has managed to provide community-based care in a large, sparsely populated geographic area, and within tight budget constraints.

We believe the province is on the threshold of change in long term psychiatric care. Ten studies in twenty five years means twenty five years of built-up evidence on real needs. Our review adds to the evidence and builds on the recommendations of the study before ours, the report of the Task Force on The Delivery of Mental Health Services. Our consultations also lead us to believe that the system wants and is ready for a resolution of the future of SHNB - no matter what is decided.

Finally, if time waits for no man, it also waits for no facility. The physical state of facilities at SHNB continues to deteriorate and is reaching a point beyond which the facilities will be unsuitable not only for the care of long term psychiatric patients, but also for any alternative use that is cost-effective.

The time is ripe for a solution, one made in Saskatchewan. We hope this report contributes to this end.

APPENDIX A: STAKEHOLDERS CONSULTED

I Seminar Participants

A. External Stakeholders

Mr. Howard Arndt, Project Manager, Saskatchewan Property Management Corporation
Ms. Byrna Barclay, President, Mental Health Association in Saskatchewan
Mr. Lem Boyd, Director, Phoenix Residential Society (Group Home)
Ms. Danni Boyd, Executive Director, Saskatchewan Alcohol and Drug Abuse Commission
Mr. Eric Braun, Consumer Representative and Member, Crocus Co-op and the Saskatchewan Mental Health Advisory Council
Mr. Cleeve Briere, Saskatoon Crisis Intervention Service and Saskatoon Mental Health Advisory Committee
Mrs. Vicki Broten, Family Member and Mental Health Association
Dr. Walter Burgess, President, Saskatchewan Psychiatric Association
Ms. Donna Challis, City Councillor Representing the Mayor of North Battleford
Mr. David Dekker, President, Battlefords Chamber of Commerce
Mrs. Evelyn Dewey, Approved Home Operator, Saskatoon
Mr. Robert Gillies, Executive Director, Regional Psychiatric Centre (Prairies)
Mr. Lorne Glowa, CUPE Local 600-5, North Battleford
Dr. David Keegan, Department of Psychiatry, University of Saskatchewan
Ms. Sue Melrose, Saskatoon Home Care District
Dr. Robin Menzies*, Clinical Director, Regional Psychiatric Centre (Prairies)
Mr. Dave Nelson, Chair, Mental Health Coalition
Judge G. E. Noble*, Advisory Board of Review (for LGWs)
Mr. George Peters, Executive Director, Continuing Care Branch, Saskatchewan Health
Mrs. Myrtle Surjik, Director, Schizophrenia Society of Saskatchewan
Mr. Dick Till**, Executive Director, Corrections Division, Saskatchewan Justice
Mr. Robert Windsor**, President, Family Advisory Council for SHNB

---

* Attending February 25 only

** Attending February 26 only

B. Mental Health Services Branch

Mr. John Labatt, Executive Director
Dr. John Elias, Associate Executive Director
Mr. Boris Titus, Assistant Executive Director
Dr. Garry Bell, Director of Programs
Mrs. Aurelia Beach, Director of Inpatient Services
Mr. Lee Spencer, Executive Director, SHNB
Dr. David Seevarathnam, Consultant Psychiatrist
Dr. Kizhake Ramachandran, Chief Psychiatrist, SHNB
Ms. Moira Gautron, Director of Patient Care, SHNB

C. Saskatchewan Health Planning Committee

Dr. John W. Elias, Chairperson
Dr. Garry Bell, Director of Programs, Central Office
Ms. Moira Gautron, Director of Patient Care, SHNB
Dr. Mohammed Hussain, Chief Psychiatrist, Prince Albert Mental Health Centre

D. RMC Resources Management Consultants Limited

Mr. Myroslaw Kohut, Senior Principal
Ms. Antoinette Alleyne, Associate

II Individuals Interviewed

Prior to the Seminar, discussions and/or interviews were held with most of the individuals that attended the Seminar. In addition, the following individuals were also interviewed.

Ms. Iris Feist, Chair, Saskatoon Regional Rehabilitation Planning & Coordinating Council
Ms. Loretta Fritz, Director, Communications & Member Services, Saskatchewan Health Care Association
Ms. Marlene Harper, President Elect, Psychological Society of Saskatchewan
Dr. John Hylton, Executive Director, Mental Health Association in Saskatchewan
Dr. M. Khatri, Chief Psychiatrist, Regina Mental Health Clinic
Mr. Patrick Lapointe, Assistant Director, Home Care Division, Continuing Care Branch, Saskatchewan Health
Dr. Ian McDonald, Chair, Working Group on Mental Health Services, Saskatoon
Ms. Debbie Miller, Psychiatric Nurse in private practice
Mr. Larry Moffatt, Executive Director, Community Living Division, Saskatchewan Social Services
Ms. Coleen Molnar, Chair, Regina Psychiatric Rehabilitation and Coordinating Council

Dr. Pat Neilson, Director of Programs, Regina Mental Health Clinic
Ms. Lorna Oliynyk, Director of Care, Battleford's Riverheights Lodge Inc.
Dr. Carol Pond, President, Saskatchewan Psychological Association
Ms. Wanda Reinbolt, Coordinator, Psychiatric Home Care, University Hospital, Saskatoon
Residents Council, Saskatchewan Hospital, North Battleford
Ms. Carole Stewart, Program Director, Phoenix Residential Society
Ms. Roberta Woods, President, Psychological Society of Saskatchewan
Ms. Barbara Wright, Executive Director, Saskatchewan Psychiatric Nurses Association
Mr. Jerry Walker, Past President, Battlefords Chamber of Commerce